STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. BUILDING 01 B. WING	11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME & REHABILITATIVE CENTER	231 N JACKSON ST OAKLAND CITY, IN47660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/09/11 Facility Number: 000327 Provider Number: 155561 AIM Number: 100273920 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Good Samaritan Home & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with two separate basements was	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on both levels including the corridors and spaces open to the corridors. The facility has a capacity of 110 and had a census of 81 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/15/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 12 hazardous area room doors, such as a room over	K0029	**K 029 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were	11/23/2011

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	100 square feet containing a large amount of combustible material such as cardboard boxes, was equipped with a self closing device on the door. This deficient practice could affect 11 residents, as well as staff and visitors in the 100 hall Station 3 area. Findings include: Based on observation on 11/09/11 at 11:15 a.m. during a tour of the facility with Maintenance Supervisor, room 105 was over one hundred square feet in size and full of at least fifteen large cardboard boxes. The door to this room was not provided with a self closing device. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		affected. Items from room 105 removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents had the potential to be affected. Items in room 105 removed **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.** Resident rooms will not be utilized for storage. Maintenance Director or designee will perform weekly rounds to monitor for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e, What quality assurance program will be put into place.** Maintenance Director will provide Quality Improvement Committee overseen by Executive Director. **Date of Completion 11-23-2011**	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 8 exits was maintained to provide safe access to the public way in accordance	K0038	**K 038** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	11/23/2011

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	with LSC Section 7.1. LSC Section 7.1.6.3 requires walking surfaces shall be nominally level. This deficient practice could affect up to 20 residents, as well as staff and visitors in the Cottage Unit # 2 during an evacuation. Findings include: Based on observation on 11/09/11 at 11:50 a.m. during a tour of the facility with the Maintenance Supervisor, the Cottage Unit # 2 south exit discharged onto a concrete platform which was connected to a concrete sidewalk which lead to the public way. The concrete platform was cracking and was uneven in several places. There was loose gravel on the platform also, making it difficult to traverse in the event of an evacuation. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		No residents were found to have been affected. Concrete landing outside of Cottage 2 emergency exit door was resurfaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents had the potential to be affected. Concrete landing outside of Cottage 2 emergency exit door resurfaced. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.** Maintenance Director will perform weekly rounds to monitor for safety on grounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e, What quality assurance program will be put into place.** Maintenance Director will bring results of rounds to Quality Improvements Committee, overseen by Executive Director, if grounds are not up to Life Safety expectations a plan of action will be implemented. **Date of Completion 11-23-2011**	
K0047 SS=E	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1			

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	Based on observation and interview, the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was provided over 1 of 8 exit doors. LSC 19.2.10.1 refers to 7.10. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect 16 residents, as well as staff and visitors in Cottage Unit # 1. Findings include: Based on observation on 11/09/11 at 10:45 a.m. during a tour of the facility with the Maintenance Supervisor, there was no EXIT sign over the east exit door from Cottage Unit # 1. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K0047	**K 047** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident was affected. Exit sign relocated appropriately above new emergency exit door **How other resident's having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident's had the potential to be affected. Exit sign relocated to appropriate emergency exit door. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.** Maintenance Director will perform weekly rounds to monitor for appropriately placed signage and proper functioning. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur i.e, What quality assurance program will be put into place.** Maintenance Director will report findings to Quality Improvement Committee overseen by Executive Director. If Life Safety requirements are not met an action plan will be implemented. **Date of Completion 11-23-2011**	11/23/2011

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K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 81 of 81 residents in the event of an emergency addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's	K0048	**K 048** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected. Disaster Policy updated to address the use of ABC type fire extinguishers located throughout the building. Disaster policy updated to reflect K class fire extinguishers located in kitchen in relationship with the use of kitchen overhead extinguishing system. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents had the potential to be affected. Disaster Policy updated to address the use of ABC type fire extinguishers located throughout the building. Disaster policy updated to reflect K class fire extinguishers located in kitchen in relationship with the use of kitchen overhead extinguishing system. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.** Maintenance Director will monitor	11/27/2011

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	written fire safety plan labeled "Disaster Plan" on 11/09/11 at 9:50 a.m. with the Maintenance Supervisor present, the fire safety plan did not address the use of the ABC type fire extinguishers located throughout the building or the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan did not include the use of the ABC type fire extinguishers or the kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher. 3.1-19(b)		and update disaster policy as changes to expectations occur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e, What quality assurance program will be put into place.** Maintenance Director will alert Quality Improvement Committee of Life Safety regulation changes. Quality Improvement Committee will assure Disaster Policy is updated as needed. **Date of Completion 11-27-2011**	
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the Health Care Facilitator Office	K0062	**K 062** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/27/2011

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	in Cottage Unit # 2 was free of obstructions to the spray pattern. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Furthermore NFPA 13, Installation of Sprinkler Systems, 4-5.51.1 requires sprinklers shall be located as to minimize obstructions to discharge. NFPA 13 at 5-6.3.3 requires a minimum of 4 inches between the sprinkler and the wall. This deficient practice could affect 20 residents, as well as staff and visitors in Cottage Unit # 2. Findings include: Based on observation on 11/09/11 at 12:05 p.m. during a tour of the facility with the Maintenance Supervisor, the pendant sprinkler head in the Health Care Facilitator Office in Cottage Unit # 2 was within one inch of the wall (ceiling bulkhead) which could restrict the spray pattern of the sprinkler head in the event the sprinkler head was actuated. This was acknowledged by the Maintenance Supervisor at the time of observation.		**practice;** No resident's were affected. Sprinkler heads in Memory Care Facilitator's office removed and relocated to an area that meet's Fire Safety codes. Sprinkler Heads in employee break room were exchanged with sprinkler heads that meet Fire Safety code. **How other resident's having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident's had the potential to be affected. Sprinkler heads in Memory Care Facilitator's office removed and relocated to an area that meet's Fire Safety codes. Sprinkler Heads in employee break room were exchanged with sprinkler heads that meet Fire Safety code. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.** Maintenance Director will perform weekly inspections to monitor for compliance for appropriate placements and condition of sprinkler heads. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur i.e, What quality assurance program will be put into place.** Maintenance Director will provide Quality Improvement Committee,	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the Employee Breakroom was free of paint. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted. This deficient practice could affect any of the 81 residents, as well as staff and visitors while in the Physical Therapy room which was part of the same smoke compartment. Findings include: Based on observation on 11/09/11 at 12:20 p.m. during a tour of the facility with the Maintenance Supervisor, the sprinkler head in the front part of the Employee Breakroom was partially covered with white paint on the fusible link. This was acknowledged by the Maintenance		overseen by Executive Director, with results of audit and if not in compliance an action plan will be developed. **Date of Completion 11-27-2011**	

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	Supervisor at the time of observation. 3.1-19(b)			
K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure cigarette butts and ashes were properly disposed of for 2 of 2 smoking areas. This deficient practice could affect any residents and staff who smoke. Findings include:	K0066	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected. Appropriate containers for cigarette butts/ashes have been placed in smoking areas. **How other residents having the potential to be affected by the same deficient practice will**	11/27/2011

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	Based on observations on 11/09/11 between 10:30 a.m. and 1:15 p.m. during a tour of the facility with the Maintenance Supervisor, the employee smoking area was using two large open concrete planters for the disposal of cigarette butts. The planters were both full with hundreds of cigarette butts each. Metal containers with self closing lids were not provided in the employee smoking area. Furthermore, the resident smoking area within the courtyard had two large concrete planters for the disposal of cigarette butts, as well as two metal containers with self closing covers. The planters were both full with hundreds of cigarette butts each, and the metal containers with self closing covers contained cigarette butts and paper trash. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3-1.19(b)		**be identified and what corrective action(s) will be taken;** All residents had the potential to be affected. Appropriate containers for cigarette butts/ashes have been placed in smoking areas. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.** Maintenance Director will perform weekly rounds to monitor for proper containers for cigarette butt/ashes disposal. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e, What quality assurance program will be put into place.** Maintenance Director will report findings to Quality Improvement Committee, overseen by Executive Director, if not compliant an action plan will be developed. . **Date of Completion 11-27-2011**	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			

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	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants in the facility. Findings include:	K0144	**K 144** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected. Remote kill switch installed in appropriate area per Life Safety. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents had the potential to be affected. Remote kill switch installed in appropriate area per Life Safety. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.** Maintenance Director will monitor/audit kill switch function by testing quarterly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e, What quality assurance program will be put into place.** Maintenance Director will provide Quality Improvement Committee, overseen by Executive Director, with results of audit and if necessary an action plan will be developed.	11/18/2011

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	Based on observation on 11/09/11 between 10:30 a.m. and 1:15 p.m. during a tour of the facility with the Maintenance Supervisor, a remote shut off device for the generator was not found. Based on interview at the time of exit interview at 1:25 p.m. on 11/09/11, the Administrator indicated the generator was installed after 2003, and further indicated there was no remote shut off device for the generator. 3.1-19(b)		**Date of Completion 11-18-2011**	